ALBERT J. SOLNIT CHILDREN'S CENTER
PROCEDURES

YOUTH CARE
Documentation Procedure

Procedure

The Albert J. Solnit Center – South Campus Interdisciplinary Treatment Teams shall create progress notes in each youth's medical record to provide complete and accurate documentation of the care and treatment the youth receives and to provide a mechanism for communication between all members of the youth's Interdisciplinary Treatment Team.

The purpose of this procedure is to ensure a standardized process whereby the Interdisciplinary Treatment Team members document a youth's progress or lack thereof toward the achievement of his or her individualized treatment goals and objectives.

Each youth's progress notes shall be reviewed in their entirety on a daily basis by each of the primary Individualized Treatment Team members.

Function

The progress notes shall serve as a legal record documenting the care that was delivered and the youth's progress toward the goals of his or her Individualized Treatment Plan.

Multidisciplinary notes are designed to ensure that each member of the youth's Interdisciplinary Treatment Team has access to the other member's information, observations and contributions to the youth's care.

The medical record may be audited and examined by Solnit's Risk Management and Quality Assurance Department to determine if adequate assessment, treatment and follow up were provided and for the purposes of improving the quality of youth care and meeting standards of care as established by the Joint Commission and the Centers for Medicare and Medicaid Services (CMS).

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Progress Notes

Solnit staff members in the following disciplines shall be authorized to document progress notes in a youth's medical record:

- Physicians
- Licensed Independent Practitioners
- Psychologists
- Social Workers
- Children Services Workers
- Education Department staff
- Occupational Therapists
- Rehabilitation Therapists
- Nurse Practitioners
- Registered Nurses
- Licensed Practical Nurses
- Licensed Registered Dietitians
- Licensed Physical Therapists
- Certified Speech Therapists
- Licensed Dentists
- Teachers
- all DCF managers
- medical students (with co-sign of Attending Physician)
- social work students (with co-sign of Licensed Social Worker)
- other students practicing at Solnit as designated by contractual agreements

Documentation

Progress notes shall be completed by the youth's Individual Treatment Team: psychiatrist, primary clinician, nurse and, when appropriate, other disciplines including rehabilitation therapists and occupational therapists that are responsible for treatment interventions documented in the youth's Individualized Treatment Plan.

Progress notes shall describe the youth's response to his or her Individualized Treatment Plan, the interventions used and the writer's recommendations for changes in the youth's Individualized Treatment Plan.

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YOUTH CARE
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Frequency of Progress Notes (Individualized Treatment Team)

Progress notes shall be written, at a minimum, weekly by all individuals on the youth's Individualized Treatment Team while the youth is in care. Depending on the acuity of the youth's needs and the treatment interventions, progress notes may be required to be written more often than weekly.

A week is defined as a weekly calendar period beginning at 12 AM Sunday and ending at 11:59 PM Saturday.

Documentation shall occur at the same time as, or as close as possible to, the event or intervention.

Note: Documentation is an ongoing process throughout each shift and shall not be reserved as an end-of-shift activity. Do not schedule blocks of time for this activity (*e.g.,* 1st shift or 3-5 pm).

Accountability

The person who gives the care, or observes a response to care, shall personally record his or her actions or observations in the progress notes.

The writer shall be held accountable for having done or observed what is recorded unless it is clearly documented by the writer that another person performed the action indicated.

Format

A narrative format (sentences) shall be utilized for progress note entries and the progress notes shall be maintained in chronological sequence. Each progress note shall include the date and time and the signature of the writer.

Contents of Shift Nursing Progress Notes

Registered Nurses, on each first and second shift, shall be responsible for documenting a shift nursing progress note for each youth. The content of the shift nursing progress note shall include the assessment of the youth and an evaluation of all care given to the youth on that shift.

Nurses shall refer to the Nursing Process in the Nurse Handbook as a guideline when charting. All assessment and care provided to the youth, as well as any response or addenda to treatment interventions shall be accurately and thoroughly documented by the conclusion of the shift.

Cross reference: Albert J Solnit Children's Center Procedure Manual, "Treatment Services Procedure: Assessment and Reassessment Procedure."

Contents of Shift Nursing Progress Notes (continued)

The shift nursing progress note shall also include the following, if applicable:

- notation of medication, prn administration and response;
- medical information and medical examinations;
  medical appointments, location, purpose and results (when available or indicate that results are pending;
- lab or test results received by telephone;
- injuries and physical complaints, the care received, the youth's response, and follow up;
- telephone contacts with physicians, family members and others involved in a youth's care;
- nursing assessment;
- any nursing care actions and the youth's response; and
- a youth's non-compliance with or refusal of recommended treatment or medication and documentation that the youth was informed of the potential consequences of non-compliance or refusal.

On each shift, the assigned coach shall report his or her work with his or her assigned youth to the Registered Nurse. This information shall be incorporated into the RN's shift note.

Third shift Registered Nurses shall document in a shift progress note any of the above activity if it occurs on the third shift and shall reflect any response and addendum to the treatment interventions.

Acute Notes

The purpose of an Acute Note is to ensure that a team member or caregiver with first-hand knowledge of an acute event documents the event, the response and any actions.

Quality and Writing Requirements

Progress notes shall be easy for others to read. To ensure quality of progress notes the following requirements apply:

- write legibly;
- write in black;
- write each entry immediately following the previous entry without leaving blank lines between entries;
- begin the note with the discipline heading;
- enter the actual date and time that the note is written;
- sign the writer's name, with license, initials or title; and
- use only the approved symbols and abbreviations.

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Corrections, Late Entries

Youth records shall never be altered. Staff shall not erase, use white out (liquid paper), obliterate or attempt to edit notes previously written. All corrections, late entries, entries made out of time sequence and addenda shall be clearly marked as such in the record, and shall be dated and timed on the day they are written and signed.

In case of error, the staff member shall draw a single line through the erroneous chart entry and write "error" above the entry followed by initials of the person making the error and the person making the correction.

Original pages of charting shall never be removed or destroyed. If errors are extensive enough that it is difficult to interpret information, it may be necessary to recopy the original material on a clean chart page. The word "recopied" shall be written across the original and it shall be kept as part of the chart.

Encounter Notes

Encounter Notes are notes that are written following an intervention with a youth and include:

- individual therapy;
- group therapy;
- family therapy sessions; and
- coaching interventions outlined in the youth's Individualized Treatment Plan.

If a youth does not attend a prescribed intervention outlined in his or her Individualized Treatment Plan, the reason for the absence and the follow up with the youth shall be documented in a progress note.